# STATE OF HAWAII DEPARTMENT OF HUMAN SERVICES

## **NOTICE TO APPLICANTS:**

In order to complete your application for social services, you <u>must</u> submit all of the following information within thirty (30) days of the date your Application for Social Services form is received. To be considered complete, the following information must be provided:

- \* You or your representative must sign and date the form.
- \* Your residence and mailing address must be complete
- \* List the name of the applicant (person or persons needing services.) You must include the names, birth dates, Social Security numbers, and whether anyone receives AFDC, Medicaid, or SSI benefits.
- \* IF YOU DO NOT RECEIVE MEDICAL ASSISTANCE FROM
  THE STATE OR SUPPLEMENTAL INCOME (SSI)
  BENEFITS, YOU NEED TO APPLY AND BE ELIGIBLE FOR
  THESE BENEFITS TO QUALIFY FOR CERTAIN SOCIAL
  SERVICE PROGRAMS, (I.E. CHORE SERVICES, ADULT DAY
  CARE SERVICES.)
- \* If you are in need of Chore Services for Adults, Foster Care Services for Adults or Day Care Serviced for Adults, you must submit a statement from a psychologist or physician licensed to practice in Hawaii which gives your diagnosis, prognosis, and the specific reason(s) you cannot manage without the service. A general statement of disability without showing its relationship to the services applied is not sufficient. A physical examination report is enclosed for your physician to complete.

The Department had thirty (30) days from the date the <u>Application for</u> Social Services is received to determine whether or not you are eligible, therefore, it is essential that you <u>submit all the noted information</u> in order that we can determine if you are eligible or not.

# IF YOU NEED AN INTERPRETER ...

We provide interpreter services on request to conduct your business with this office. If you need an interpreter in a particular language, point to that language below:

	မြန်မာဘာသာနှင့်စကားပြန်လိုလျှင် ဤနေ ရာကိုလက်ညှိုးဖြင့်ညွှန်ပြပါ။	Burmese
	ចខ្ពុលជីនេះចើង្ហកត្រូចការអ្នកចកច្រែកាសានេះ	Cambodian
	E punto guene unnesesita intepete ni esta na lenguahe.	Chamorro
	Itini ikei ika pun ke osupwangen emon chon chiaku non kapasen ei neni ika fonu.	Chuukese
(F)	Inā pono he mahele 'ōlelo Hawai'i iā 'oe, e kuhikuhi mai iā 'ane'i nei.	Hawaiian
	Itudom ditoy no masapol mo ti interpreter ti sarita nga Ilocano.	Ilocano
	お話しになる言語を指して下さい。	Japanese
	여러분이 이언어를 이해하시고 사용하시면 이곳을 가르키십시요 저희가 통역을 제공하겠읍니다	Korean
	Kom fin nikin, kom enenu in oasr met leng kahs lom.	Kosraen
	ຖ້າທ່ານເວົ້າແລະເຂົ້າໃຈພາສານີ້, ໃຫ້ຊີໃສ່ທີ່ນີ້. ນາຍພາສາຈະຊ່ວຍທ່ານ	Lao
	如果您明白此種語言,請指向本文。我們會提供該種語言翻譯員。 Mandarin o	r Cantonese
	Jitōñe ñe elōñ am ñoñ rikook kajin.	Marshallese
	ldih wasabt ma ke anahne soun kawehwe ni lokala wet.	Pohnpeian
	Afai e te mana'omia le faaliliu upu ile gagana Samoa faailoa mai faamolemole.	Samoan
	Apunte aqui si necesita un traductor en Español.	Spanish
	Ituro dito kung nanganga-ilangan ka ng tagapagsalin sa ganitong wika.	Tagalog
	กรุณาชีตรงนีถาตองการผูชวยแปลภาษา	Thai
	Tuhu ki he tohi ni Kapau'oku Fie. ma'u ha Tokoni ke Fakamatala atu 'ae 'uhin 'oe ton.	ga Tongan
	Chi vao dây nêu ban cân một thông dịch viên cho ngôn ngũ Vietnam.	Vietnamese
	Itudlo diri kung nanginahanglan ka ug taghubad niining pinulongan. Visaya	ın (Cebuano)
	Mu guchum ngarag ni faamra gabadag ninge thilyeg bee e thin rom.	Yapese



Interpretation services may be provided at no charge in accordance with Chapter 371-33, Hawaii Revised Statutes.

For more Information about Hawaii's Language Access Law - Chapter 371, HRS (Part II), please visit <a href="https://www.hawaii.gov/labor/ola">www.hawaii.gov/labor/ola</a> or call the Office of Language Access at (808) 586-8730.

State of Hawai'i

State of Hawaii
DEPARTMENT OF HUMAN SERVICES
Social Services Division
Adult & Community Care Services Branch

### **MEDICAL STATEMENT**

#### **Consent to Release Information:**

#### PLEASE MAIL COMPLETED REPORT TO:

A D U L T I N T A K E U N I T ADULT & COMMUNITY CARE SERVICES OAHU SECTION

> Department of Human Services 420 Waiakamilo Road, Suite 202 Honolulu, Hawaii 96817-4941

					.:. <i>I</i>	/
PRINT	Last Name	First Name	Initi	al	Birth	date
				[	] M	□F
	Address	City	Zip C	ode		
I hereby	authorize the evaluating physicia	n, physician assistant, ad	vanced pract	ice registe	red nu	erse, or
medical f	acility to release to the Departme	ent of Human Services ar	nd its designe	es any inf	ormat	ion
related to	my past and present medical car	e, including substance at	ouse history	and any in	forma	tion
related to	my HIV/AIDS status. I underst	and this information shal	l be used for	the sole a	nd lim	iited
purpose o	of determining eligibility for serv	ices provided by the Adı	ılt and Comr	nunity Car	re Serv	rices
Branch.	<i>5 5 7</i>			-		
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Other C	omments:					
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